

**WISCONSIN MEDICAID  
PRIOR AUTHORIZATION AMENDMENT REQUEST**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.  
**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization Amendment Request Completion Instructions (HCF 11042A).

**SECTION I — RECIPIENT INFORMATION**

|   |  |
|---|--|
| 1. Today's Date                                   | 2. Previous Prior Authorization Number   |
| 3. Name — Recipient (Last, First, Middle Initial) | 4. Recipient Medicaid Identification No. |

**SECTION II — PROVIDER INFORMATION**

|   |   |
|---|---|
| 5. Name — Billing Provider                                    | 6. Billing Provider's Medicaid Provider No. |
| 7. Address — Billing Provider (Street, City, State, ZIP Code) | 8. Amendment Effective Dates                |

**SECTION III — AMENDMENT INFORMATION**

9. List reasons for Amendment Request

10. Indicate procedure(s) to be amended by hours per day and days per week, multiplied by the number of weeks.

Registered Nurse \_\_\_\_\_

Licensed Practical Nurse \_\_\_\_\_

Home Health Aide \_\_\_\_\_

Physical Therapist \_\_\_\_\_

Occupational Therapist \_\_\_\_\_

Speech-Language Pathologist \_\_\_\_\_

Personal Care Worker \_\_\_\_\_

Other \_\_\_\_\_

11. **SIGNATURE** — Requesting Provider

12. Date Signed